Supreme Court, U.S.
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No. 99-183

IN THE
Supreme Court of the United States

MARY–LOUISE O'NEAL,

Petitioner,

v.

FHP, INC., LOMA LINDA FACULTY MEDICAL GROUP, INC. and BONNIE BARNES,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE CALIFORNIA SUPREME COURT

BRIEF IN OPPOSITION FOR RESPONDENT RECHE CANYON REHABILITATION AND HEALTHCARE CENTER, INC.

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QUESTION PRESENTED

The question presented in this Petition for a Writ of Certiorari is whether a medicare beneficiary can maintain a state court action against her health maintenance organization arising from the alleged delay in the provision of benefits [in this case physical therapy following a stroke] without first participating in the administrative review process mandated by the Medicare Act. *See* 42 U.S.C. § 1395mm(c)(5)(A), 42 C.F.R. §§ 417.600-417.638.

Secondary to this issue is the question of whether the facts presented in this matter fall within the *special case* exception to the Medicare administrative review process established by this Court in *Heckler v. Ringer,* 466 U.S. 602, 104 S. Ct. 2013, 80 L. Ed. 2d 622 (1984).

Respondents RECHE CANYON REHABILITATION AND HEALTHCARE CENTER, INC., and CYNTHIA M. GLEASON respectfully submit that the answer to the first question is in the affirmative, that Petitioner MARY LOUISE O'NEAL was required to participate in the Medicare Act administrative review process, and that her failure to do so results in her attempted state court action being administratively preempted and barred by the resulting lack of subject matter jurisdiction.

Respondents respectfully submit that the answer to the second question is in the negative, and that neither *Heckler* nor the lower court cases decided thereafter are consistent with the conclusion that O'NEAL presents such a *special case* that she is, or should be, exempt from the Medicare Act's administrative review process.

In sum, Respondents respectfully submit that the California Courts' decisions in this matter are sound, that no basis for review by this Court exists, and that O'NEAL's Petition for a Writ of Certiorari must be ***DENIED***.

STATEMENT PURSUANT TO RULE 29.6

Pursuant to Supreme Court Rule 29.6, Respondent RECHE CANYON REHABILITATION AND HEALTHCARE CENTER, INC. states that it is a wholly owned subsidiary of InterWest Medical Corporation, a publicly traded company, with its principal offices in Fort Worth, Texas.

TABLE OF CONTENTS

	Page
Question Presented	i
Statement Pursuant to Rule 29.6	ii
Table of Contents	iii
Table of Cited Authorities	v
Introduction	1
Statement of Facts	1
A. The Parties	1
B. The Events Leading Up to This Claim	2
Statement of the Case	5
I. O'NEAL Was Required To Exhaust Her Administrative Remedies Under The HCFA Review Procedure	6
II. California Case Law Establishes That O'NEAL Was Required To Participate In The HCFA Review Procedure	12
III. The Federal Cases Relied Upon By O'NEAL Are Either Distinguishable Or Inapplicable	17
A. *Ardary* Is Distinguishable	17

Contents

Page

B. *Wartenberg* and *Plocica*, Like *Ardary*, Are Distinguishable 21

C. The Other Federal Cases Cited by O'NEAL Are Inapplicable 24

IV. Public Policy Supports The Preemption Of O'NEAL's Claims 27

Conclusion 29

TABLE OF CITED AUTHORITIES

Page

Cases:

Ardary v. Aetna Health Plans, 98 F.3d 496 (9th Cir. 1996), *cert. denied*, 520 U.S. 1251, 117 S. Ct. 2408, 138 L. Ed. 2d 174 (1997) ..... *passim*

Berman v. Abington Radiology Associates, 1997 WL 534804 (E.D. Pa. 1997) 24, 25

Bodimetric Health Services v. Aetna Life & Cas., 903 F.2d 480 (7th Cir. 1990) 7, 10, 16, 17

Heckler v. Ringer, 466 U.S. 602, 104 S. Ct. 2013, 80 L. Ed. 2d 622 (1984) ..... *passim*

Plocica v. Nylcare of Texas, 43 F. Supp. 2d 658 (N.D. Tex. 1999) 21, 22, 23, 27

Redmond v. Secure Horizons, 60 Cal. App. 4th 96, 70 Cal. Rptr. 2d 174 (1997) ..... *passim*

Roen v. Sullivan, 764 F. Supp. 555 (W.D. Minn. 1991) 7, 17

Talbot v. Lucy Corr Nursing Home, 118 F.2d 215 (4th Cir. 1997) 24, 25

Wartenberg v. Aetna U.S. Health Care, Inc., 2 F. Supp. 2d 273 (E.D.N.Y. 1998) 21, 22, 23, 27

Page

Wilkins v. Sullivan, 889 F.2d 135 (9th Cir. 1989) .. 7, 17

Winkler v. Interim Health Services, Inc., 36 F. Supp. 2d 1026 (M.D. Tenn. 1999) 24, 26, 27

Zamora-Quezada v. Health Texas, 34 F. Supp. 2d 433 (W.D. Tex. 1998) 24, 25, 26, 27

Statutes:

29 U.S.C. § 794 25

42 U.S.C. § 405(b) 17

42 U.S.C. § 405(g) 6, 8, 9, 17, 24, 30

42 U.S.C. § 405(h) 8, 30

42 U.S.C. §§ 1395, *et seq.* 24

42 U.S.C. §§ 1395c, *et seq.* 6

42 U.S.C. § 1395ff 6, 17

42 U.S.C. § 1395ff(a) 16

42 U.S.C. § 1395hh 6

42 U.S.C. §§ 1395j, *et seq.* 6

Page

42 U.S.C. § 1395mm 6

42 U.S.C. § 1395mm(b)(2) 8

42 U.S.C. § 1395mm(c) 6

42 U.S.C. § 1395mm(c)(5) 6

42 U.S.C. § 1395mm(c)(5)(A) ..... i, 7, 30

42 U.S.C. § 1395mm(c)(5)(B) 16, 17

42 U.S.C. § 1395mm(I)(6) 16

42 U.S.C. § 1983 24

42 U.S.C. § 12182(a) 25

California Insurance Code, Section 790.03 12

Other Authorities:

42 C.F.R. §§ 405.701-405.753 7

42 C.F.R. §§ 405.801-405.877 7

42 C.F.R. §§ 417, *et seq.* 6

42 C.F.R. §§ 417.600-417.638 ..... i, 6, 7

	Page
42 C.F.R. § 417.606	7, 9
42 C.F.R. § 417.606(a)(3)	9
42 C.F.R. § 417.616	7
42 C.F.R. § 417.620	7
42 C.F.R. § 417.634	7
42 C.F.R. § 417.636	7

INTRODUCTION

In a Petition for a Writ of Certiorari rife with hyperbole and misstatements of fact, and founded upon inapplicable statutory and case law, Petitioner MARY-LOUISE O'NEAL ("O'NEAL") seeks to overturn the California Supreme Court's refusal to review the ***unpublished*** Opinion of the California Court of Appeal, affirming the Judgment of the San Bernardino County Superior Court sustaining Respondents' Demurrers to O'NEAL's First Amended Complaint *without leave to amend*. As will be demonstrated herein, O'NEAL's First Amended Complaint was a poorly disguised attempt to re-characterize federal Medicare Act benefits' determinations into common law tort claims. Both the Trial and Appellate Courts saw through this transparent attempt to avoid the Medicare Act's exclusive administrative review process, and correctly rejected O'NEAL's common law tort claims. Notwithstanding O'NEAL's impassioned pleas based upon sympathetically colored facts, both California and federal law required the dismissal of this action. Therefore, O'NEAL's Petition for a Writ of Certiorari must be rejected, and the decisions of California Courts ***AFFIRMED***.

STATEMENT OF FACTS

A. The Parties

O'NEAL is an elderly resident of San Bernardino County, California. [C.T. 230, ¶ 25] O'NEAL receives Medicare benefits which form the principal source of her health care financing.

Respondent FHP HEALTHCARE CORPORATION ("FHP"), is a Health Maintenance Organization ("HMO") which provides health insurance benefits to senior citizens. [C.T. 230, ¶ 26] In or about January 1995, O'NEAL enrolled in the FHP

Senior Plan. [C.T. 234, ¶ 41] As consideration for her enrollment, O'NEAL assigned her Medicare benefits to FHP. [C.T. 235, ¶ 43] A copy of O'NEAL's FHP Senior Plan policy was incorporated by reference into to the First Amended Complaint as Exhibit "A." [C.T. 269-315]

Respondent LOMA LINDA FACULTY MEDICAL GROUP ("LOMA LINDA") was the health care provider selected by O'NEAL under her FHP Senior Plan, and was primarily responsible for administering O'NEAL's benefits under that Plan. [C.T. 231, ¶ 27] Respondent BONNIE BARNES ("BARNES") was the LOMA LINDA case manager responsible for O'NEAL's care. [C.T. 231, ¶ 28]

Respondent RECHE CANYON REHABILITATION AND HEALTH CARE CENTER, INC. ("RECHE CANYON") is a skilled nursing facility. [C.T. 231, ¶ 29] RECHE CANYON contracted with LOMA LINDA to provide skilled nursing care to its patients, one of whom was O'NEAL. Respondent CYNTHIA M. GLEASON ("GLEASON") was a social services person at RECHE CANYON who worked on O'NEAL's case. [C.T. 231, ¶ 30]

B. The Events Leading Up to This Claim

On December 10, 1995, O'NEAL suffered a stroke. [C.T. 236, ¶ 45] O'NEAL was transported to the San Bernardino County Medical Center, where her stroke was confirmed. [C.T. 236, ¶ 45] Later that same day, O'NEAL was transported to Loma Linda Community Medical Center, her FHP plan hospital. [C.T. 236, ¶ 46]

O'NEAL was hospitalized at Loma Linda until December 12, 1995 [C.T. 236, ¶ 47], when she was transferred to RECHE CANYON for rehabilitation. [C.T. 237, ¶ 51] O'NEAL's therapy at RECHE CANYON included occupational, speech and physical therapy. [C.T. 237, ¶ 52]

From December 16, 1995 through December 31, 1995,

O'NEAL received extensive physical therapy and rehabilitation at RECHE CANYON. [C.T. 238, ¶ 56] On January 1, 1996, FHP determined that O'NEAL had made "excellent progress," and was ready for discharge to a convalescent facility. O'NEAL's son, Enos Doyle ("Mr. Doyle"), protested this decision to BARNES. [C.T. 239, ¶ 59] When BARNES refused to reconsider the decision, Mr. Doyle contacted a FHP case manager to request further reconsideration. In the second week of January 1996, FHP's decision to discharge O'NEAL was rescinded. [C.T. 240, ¶ 61] At no time during this process was O'NEAL denied any physical therapy or rehabilitation.

On January 23, 1996, FHP determined that O'NEAL had *plateaued*,[1] and advised Mr. Doyle that it intended to discontinue her therapy and transfer her to a convalescent facility. Mr. Doyle again protested, O'NEAL was reevaluated, and the decision to transfer her to a convalescent facility was revoked. [C.T. 240- 241, ¶ 63] As a result, O'NEAL's rehabilitative care continued throughout the remainder of January 1996. [C.T. 241, ¶ 64]

On January 30, 1996, FHP again determined that O'NEAL should be transferred to a convalescent care facility. [C.T. 241-242, ¶¶ 66-68] In essence, FHP determined that O'NEAL no longer needed skilled nursing care. [C.T. 242, ¶ 68] This was confirmed in the Order of Discharge from RECHE CANYON. [C.T. 242, ¶ 70]

On February 2, 1996, O'NEAL was discharged from RECHE CANYON and admitted into Crestview Convalescent Hospital. [C.T. 242, ¶ 71] It is ***undisputed*** that throughout her stay at RECHE CANYON, O'NEAL was never denied any of the physical therapy or rehabilitative care which she requested

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[1] In medical parlance, a patient has *plateaued* when the health care provider determines that the patient has become stable, or obtained the maximum recovery by virtue of the medically necessary rehabilitation or treatment.

[C.T. 241, ¶ 54], and that all of this treatment was paid for by FHP. [C.T. 228, ¶ 23-24; Petition 10, 11, 12, 22, 23, 27, 28]

O'NEAL received a physical therapy evaluation at Crestview, and from February 2, 1996 through June 6, 1996, O'NEAL continued receiving restorative nursing assistance and treatment at Crestview. [C.T. 243, ¶ 74]

On June 6, 1996, O'NEAL was evaluated by Dr. Bernard E. Tilton. [C.T. 243, ¶ 24] Dr. Tilton prepared a report which recommended continued physical therapy for O'NEAL. [C.T. 243, ¶ 75] Upon receiving this report, BARNES authorized Crestview to provide increased physical therapy to O'NEAL. [C.T. 244, ¶ 76] Thereafter, to improve the levels of O'NEAL's physical therapy, LOMA LINDA ordered O'NEAL transferred to a new skilled nursing facility, Heritage Gardens, on July 2, 1996. [C.T. 244, ¶ 78] O'NEAL's physical therapy treatment continued at Heritage Gardens until July 18, 1996, at which time FHP and/or LOMA LINDA[2] again determined that O'NEAL had *plateaued*. [C.T. 244, ¶ 79]

At this time, O'NEAL was discharged to her home. In order to continue with O'NEAL's physical therapy, FHP and LOMA LINDA offered to provide a visiting therapist for O'NEAL up to three times per week. [C.T. 244, ¶ 79] At no time was O'NEAL ever denied the necessary rehabilitation or therapy, and all of the rehabilitation and therapy was paid for by FHP. [Petition 10, 11, 12, 22, 23, 27, 28] O'NEAL never sought increased levels of therapy or rehabilitation through the Health Care Financing Administration ("HCFA") administrative review process [See, *infra*, pages 6 – 13] nor did O'NEAL or her son, Mr. Doyle, make any written objection regarding the level of O'NEAL's treatment. Rather, after O'NEAL had fully recovered from her stroke, this litigation was filed..

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[2] RECHE CANYON had no input whatsoever regarding O'NEAL's health care, treatment, or rehabilitation after she was transferred from its facility to Crestview Convalescent Hospital on February 2, 1996.

STATEMENT OF THE CASE

O'NEAL filed her Complaint on January 13, 1997. [C.T. 1-52] Respondents demurred to the Complaint, alleging that O'NEAL's claims were preempted by the Medicare Act and that the California Courts lacked subject matter jurisdiction to adjudicate O'NEAL's claims. [C.T. 73-91; 92-101; 143-146] The Demurrers were sustained with leave to amend on May 21, 1997. [C.T. 217-218] The Trial Court specifically held that "[O'NEAL] has failed to exhaust her administrative remedies as required by federal statute." [C.T. 218, ¶ 1]

On June 20, 1997, O'NEAL filed her First Amended Complaint. [C.T. 221-324] The First Amended Complaint was ***virtually identical*** to the original Complaint, and contained the same defects. Therefore, Respondents demurred to the First Amended Complaint. [C.T. 325-345; 365-368; 369-400] On September 8, 1997, the Superior Court sustained all of the demurrers *without leave to amend* and entered a Judgment of Dismissal. [C.T. 552-556; 561-562; R.T. 10-12]

On November 7, 1997, O'NEAL filed a Notice of Appeal to the California Court of Appeal. Thereafter, on February 5, 1999, the Court of Appeal filed its Opinion affirming the Trial Court's Judgment of Dismissal. [Petition, Appendix A] O'NEAL next sought review by the California Supreme Court, but her Petition for Review was summarily denied by the Court on April 28, 1999. [Petition, Appendix C] It is from this denial of review that O'NEAL now seeks review by this Court.

I

O'NEAL WAS REQUIRED TO EXHAUST HER ADMINISTRATIVE REMEDIES UNDER THE HCFA REVIEW PROCEDURE

In this case, O'NEAL's claims arise as a direct result of Respondents' benefit determinations under the federal Medicare guidelines. O'NEAL contends that Respondents delayed in providing rehabilitation services to which she believed she was entitled, and seeks emotional distress damages as a result of the alleged delays. Respondents contend that O'NEAL's claims are preempted by the federally mandated HCFA administrative review process, and that having failed to redress her grievances in that process, O'NEAL is jurisdictionally barred, or administratively preempted, from pursuing her state law tort claims. The history and framework of the Medicare program is important to this analysis.

The federal Medicare program is governed by a detailed set of regulations prescribed by the Secretary of Health and Human Services. These regulations are set forth in the Medicare Act [42 U.S.C. § 1395hh] and in Title 42 of the Code of Federal Regulations. 42 C.F.R. § § 417, *et seq*. The Medicare Act applies to and regulates HMOs [such as FHP] that contract with the HCFA to arrange for the provision of medical and hospital services to Medicare recipients enrolled with the HMO. 42 U.S.C. § 1395mm. The HMO must provide its Medicare enrollees with all of the services covered in Medicare Parts A and B [42 U.S.C. § § 1395c, *et seq*. and 1395j *et seq*.] which are available to individuals residing in the geographic area served by the HMO. 42 U.S.C. § 1395mm(c).

The Social Security Act, as amended, and its supporting regulations provide a multi-level administrative review process for parties dissatisfied with the original disposition of their Medicare benefits claims by an HMO. See, 42 U.S.C. § § 405(g), 1395ff and 1395mm(c)(5); 42 C.F.R. § § 417.600 -

417.638. See also, *Bodimetric Health Services v. Aetna Life & Cas.* , 903 F. 2d 480, 483 (7th Cir. 1990). ***The HCFA administrative review process is identical for recipients of Medicare benefits on a private pay basis and for subscribers to Medicare affiliated HMOs like FHP.*** Compare, 42 C.F.R. §§ 405.701 - 405.753, 42 C.F.R. §§ 405.801 - 405.877, and *Wilkins v. Sullivan,* 889 F. 2d 135, 138 (9th Cir. 1989) with 42 U.S.C. § 1395mm(c)(5)(A), 42 C.F.R. §§ 417.600- 417.638 and *Roen v. Sullivan,* 764 F. Supp. 555, 557 (W.D. Minn. 1991).

The administrative review process set forth in 42 C.F.R. 417.600-417.638 applies to all benefit appeals by beneficiaries of Medicare affiliated HMOs. The HCFA process contains six separate steps. They are:

(1) An initial determination of coverage or no coverage by the HMO [42 C.F.R. § 417.606].

(2) If the patient disagrees with the initial determination, the patient can request reconsideration by the HMO [42 C.F.R. § 417.616.].

(3) If the patient still disagrees with the organization's reconsideration decision, the claim is reviewed by a representative of the HCFA [42 C.F.R. § 417.620].

(4) If the patient contests the determination of the HCFA representative, a hearing is held before an Administrative Law Judge [42 C.F.R. § 417.634].

(5) If the patient disagrees with the Administrative Law Judge's decision, the patient can make a final appeal to the HCFA Appeals Council [42 C.F.R. § 417.634].

(6) Finally, if the patient is dissatisfied with the Appeals Council ruling, and if the amount in controversy is $1,000 or more, the patient can bring an action in the District Court against the Secretary of Health and Human Services to contest the benefit determination [42 C.F.R. § 417.636].

In this case, O'NEAL's First Amended Complaint alleges that she received an initial determination which discontinued certain rehabilitation benefits to which she

believed she was entitled. That determination was informally protested by O'NEAL's son, and the requested rehabilitation benefits were continued. O'NEAL ***concedes*** that she received ***all*** of the rehabilitation treatment that she requested, and at no cost to her. [Petition 10, 11, 12, 22, 23, 27, 28; C.T. 228] All of this occurred without the necessity of HCFA review. The congressionally mandated system worked effectively in this case. Pursuant to 42 U.S.C. § 1395mm(b)(2) and 42 U.S.C. § 405(g) and (h), O'NEAL is not entitled to resort to the judicial process. If she desired additional benefits or the imposition of civil penalties against Respondents for the alleged delays in the process, she was required to proceed through the HCFA review process and, if dissatisfied at the conclusion of that process, to proceed in the District Court against the Secretary of Health and Human Services. O'NEAL having failed to do so, the California courts lacked the subject matter jurisdiction to adjudicate her claims against Respondents. Therefore, the dismissal by the Trial Court, the subsequent affirmance by the Court of Appeal, were proper under the law.

The scope of Section 405(g)'s administrative exhaustion requirement was considered by this Court in *Heckler v. Ringer* (1984) 466 U.S. 602, 104 S.Ct. 2013, 80 L.Ed.2d 622 ("*Heckler*"). After analyzing the HCFA administrative review process [*See*, *Heckler v. Ringer, supra*, 466 U.S. at 604-606], Chief Justice Rehnquist held that Section 405(g) is the only avenue for judicial review of benefits determinations, and that the exhaustion of ***all*** steps in the HCFA administrative review process is a prerequisite to judicial jurisdiction for any claim ***arising under*** the Medicare Act. *Id,* at 617. Further, the *Heckler* opinion stated that "Section 405(g) consists of a ***non-waivable requirement*** that a claim for benefits shall have been presented to the Secretary." *Id.* [Emphasis added] Finally, the Court held that the determination of whether a beneficiary's claims are "***arising under***" the Medicare Act must be "***construed quite broadly***." *Id,* at 615.

In the instant matter, there is ***no dispute*** that O'NEAL failed to participate in any step in the HCFA administrative review process prior to the commencement of this litigation. Pursuant to Section 405(g), this non-waivable administrative review requirement constitutes a subject matter jurisdiction bar to O'NEAL's commencement of litigation. *Id,* at 617. Thus, it is clear that the Trial Court correctly granted Respondents' Demurrers, and that the Judgment of Dismissal was properly affirmed by California's Appellate Courts. Further, even assuming *arguendo* that she could avoid this subject matter jurisdiction defect, O'NEAL's claims ***must*** have been filed in the federal courts ***and*** the Secretary of Health and Human Services was an indispensable party to that action.

In her Petition, O'NEAL argues that the HCFA administrative review process is inapplicable because the rehabilitation treatment was ultimately provided by Respondents without any obligation for payment by O'NEAL. [Petition 10, 11, 12, 22, 23, 27, 28] This argument ***misses the mark***, and ignores the plain language of 42 C.F.R. § 417.606 (a)(3) which defines an "organization decision" to include:

> "(3) The HMO's or CMP's refusal to provide services that the enrollee believes should be furnished or arranged for by the HMO or CMP and the enrollee has not received the services outside the HMO or CMP."

O'NEAL's purported common law tort allegations ***directly relate*** to the alleged denial of, or the delay in providing, skilled nursing care, physical therapy, and rehabilitative care. These grievances are specifically covered by the language of Section 417.606, and are subject to the HCFA administrative review process mandated by 42 U.S.C. § 405(g). O'NEAL's attempt to avoid participating in this Congressionally mandated

administrative process is misplaced, and the preemption resulting from her failure to participate is absolute.

Similarly, O'NEAL's argument that her state law claims are collateral to a claim for benefits is misplaced. As the Seventh Circuit held in *Bodimetric Health Services vs. Aetna Life & Cas., supra*, 903 F. 2d 480, 487:

> "A party cannot avoid the Medicare Act's jurisdiction by simply styling its attack as a claim for collateral damages instead of a challenge to the underlying denial of benefits. If litigants who have been denied benefits could routinely obtain judicial review of these decisions by recharactering their claims under state and federal causes of action, the Medicare Act's goal of limited judicial review for a substantial number of claims would be severely undermined."

In sum, O'NEAL was required to participate in the administrative review process. She concedes that she failed to do so. This concession is ***fatal*** to O'NEAL's claim.

Finally, O'NEAL's argument that the benefits which she sought fell within the optional supplemental plan provisions of her FHP Senior Plan and, therefore, were not subject to the Medicare administrative review requirements [Petition 28 - 29] is ***misplaced and misleading***. In her Petition, O'NEAL contends that the determination of whether she was entitled to the subject rehabilitative therapy is governed by the FHP contract, and not by the Medicare Act guidelines. ***This argument ignores the clear language of the FHP insurance contract*** [C.T. 265-319] which provides that while O'NEAL was a patient at a skilled nursing care facility, FHP would provide physical, speech and occupational therapy under the following guidelines:

> "PLAN COVERS ALL SERVICES. YOU PAY nothing for up to 100 days per benefit period for as long as daily skilled nursing care is determined to be medically necessary by your primary care physician ***in accordance with Medicare guidelines***." [C.T. 296]

Similarly, the applicability of the Medicare guidelines to all other services rendered under the FHP policy is confirmed in the "Exclusions and Limitations" portion of the policy which denies coverage for:

> "All services and items not reasonable and necessary for the diagnosis and treatment of illness or injury as determined by an FHP plan physician ***using Medicare guidelines*** relying upon professionally recognized standards of practice except as specifically stated elsewhere in your evidence of coverage and disclosure form." [C.T. 297]

Thus, contrary to O'NEAL's assertions, all of the relevant benefits determinations applicable to O'NEAL's rehabilitation therapy were governed by the Medicare guidelines. Review under the HCFA administrative review process was mandatory. Hence, O'NEAL's First Amended Complaint was properly dismissed by the Trial Court. That Judgment was properly affirmed by the Court of Appeal and the California Supreme Court [through its denial of O'NEAL's Petition for Review], and must again be ***AFFIRMED*** by this Court through the rejection of O'NEAL's Petition for a Writ of Certiorari.

II

CALIFORNIA CASE LAW ESTABLISHES THAT O'NEAL WAS REQUIRED TO PARTICIPATE IN THE HCFA REVIEW PROCEDURE

The focal issue in this case is whether O'NEAL was required to participate in the HCFA administrative review process as a prerequisite to commencing any litigation arising from the alleged delay in providing her with physical and/or occupational rehabilitation/therapy. This precise issue was recently decided by the California Court of Appeal in *Redmond v. Secure Horizons, supra,*60 Cal.App.4th 96 ("*Redmond*"). RECHE CANYON respectfully submits that the *Redmond* decision correctly interprets the federal Medicare statutes, and mandates that the Trial Court's Judgment of Dismissal has been properly ***AFFIRMED*** by the California Appellate Courts.

In *Redmond*, Plaintiff Thelma Redmond brought a bad faith action against Secure Horizons and PacificCare, Inc., her HMOs. Redmond claimed that Secure Horizons had denied her coverage for "life saving surgery." After undergoing the surgery, paying for it herself, and then obtaining full reimbursement from Secure Horizons, Redmond filed a state court action against Secure Horizons for Breach of Contract, Breach of the Implied Covenant of Good Faith and Fair Dealing in violation of *California Insurance Code*, Section 790.03, and intentional and negligent infliction of emotional distress. The causes of action were based upon Secure Horizons' initial denial of Redmond's request for coverage, and its subsequent delay in reimbursing Redmond for her medical expenses. Like O'NEAL herein, Redmond ***conceded*** that (1) she ultimately received all of the medical treatment that she requested from Secure Horizons, and (2) Secure Horizons paid for all of the medical treatment in full. Redmond sought monetary damages for "loss of use" of the monies she expended for the medical services prior to reimbursement by Secure Horizons, emotional

distress damages resulting from the initial coverage denial and the subsequent delay in reimbursement, and attorney's fees and costs incurred in obtaining reimbursement of the medical expenses from Secure Horizons. *Redmond v. Secure Horizons*, *supra*, 60 Cal.App.4th at 99.

Secure Horizons demurred to Redmond's Complaint, arguing that the California courts lacked subject matter jurisdiction because Redmond's claim was one "arising under" the Medicare Act and was subject to the ***exclusive*** HCFA administrative review process. Secure Horizons argued that because Redmond failed to submit to the administrative review process, she was barred from bringing an action for damages. Redmond countered with the argument that she was not required to participate in the HCFA administrative review process because her action was not a coverage or reimbursement case, but rather an insurance bad faith case. *Id.* at 99-100.

The Trial Court granted Secure Horizons' Demurrer without leave to amend, holding that Redmond's "tort and contract claims are inextricably intertwined with the denial of Medicare benefits and are therefore subject to the administrative procedures mandated by the Medicare Act." *Id.* at 100. Redmond appealed.

The Court of Appeal ***affirmed***. The Court identified the dispositive issue as "whether [Redmond's] causes of action were based on a claim which was subject to the exclusive review provisions of the Medicare Act." *Id.* at 100. The *Redmond* Court, like the Trial and Appellate Courts herein, acknowledged that claims which arise under the Medicare Act must be brought before the Secretary of Health and Human Services through the HCFA administrative review process. Judicial review of such claims is available ***only after*** the claimant has pressed the claim through each level of the administrative review process to a ***final*** decision by the Secretary, and even then such review may ***only*** be obtained in

the federal courts. *Id.* at 101. Finally, the *Redmond* Court held that claims which are within the purview of the HCFA administrative review process are ***never*** within the jurisdiction of a state court. *Id*, at 101.

Next, the *Redmond* Court analyzed the crucial question of whether Redmond's claims "[arose] under the Medicare Act." First, the Court considered Redmond's contention that because her claims were based upon her contractual relationship with Secure Horizons, her claims did not arise under the Medicare Act. In rejecting this contention, the Court noted that Redmond's action was based on allegations that Secure Horizons wrongfully denied coverage for her surgery and then wrongfully delayed reimbursement of the expenses for her surgery. The Court concluded that such claims were required to be resolved through the HCFA review process and, therefore, ***arose under*** the Medicare Act. *Id.* at 101-102.

The Court then considered Redmond's argument that her causes of action were not actually a claim for benefits, since she had already received all of the medical treatment and had obtained full reimbursement from Secure Horizons for her expenses. This argument was also rejected, with the Court holding that irrespective of the fact that Redmond had received the services and been reimbursed for her costs, her breach of contract and bad faith causes of action to recover consequential damages arising out of the delay in providing or paying for these services were "inextricably intertwined" with the claim that she was entitled to receive the services in the first place. *Id.* at 102.

The Court also rejected Redmond's argument that her Complaint was not based on her entitlement to benefits but, rather, on Secure Horizons' "conduct with respect to her claim for benefits," noting that "the alleged wrongfulness of [Secure Horizons'] conduct depends on whether [Redmond] was entitled to payment of her claim." *Id*, at 102.

Finally, the Court considered Redmond's argument that while the administrative review process provides a remedy for adverse coverage determinations, it does not provide a remedy for

wrongful denial or delay in paying a claim. *Id,* at 102-103. In rejecting this argument, the Court of Appeal stated:

> "The administrative review process applies not only to coverage determinations but also to any other determination *with respect to* a claim for benefits, and the Secretary [of Health and Human Services] is authorized to order civil money penalties or any other remedies authorized by law if an [HMO] fails to provide required services. If [Redmond] had pressed her claim through the administrative review process and established that the [HMOs] initially wrongfully denied coverage, the Secretary could have found that [the HMOs] had failed to provide required services. The Secretary would then have been authorized to remediate the harm which arose from this conduct prior to [the HMOs'] ultimate reimbursement of [Redmond's] claim. **[Redmond's] contention that she had been injured by the [HMOs'] initial denial and subsequent delayed payment of her claim was a claim which the Secretary was authorized to resolve because it required a determination with respect to [her] claim for benefits.**"
>
> *Id*, at 103 [Emphasis added].

In essence, the *Redmond* Court's analysis was virtually identical to the reasoning of the courts herein in rejecting O'NEAL's claims. O'NEAL has raised, both in the trial court and on appeal, virtually identical arguments to those proffered by the Plaintiff in *Redmond*. As an example, O'NEAL argues that her claims are not subject to the HCFA administrative review process because "the Complaint nowhere claims that rehabilitation care was not *ultimately* provided. Nor is there any allegation that O'NEAL has any further obligation for payment of the

rehabilitation care." [Petition 10, 11, 12, 22, 23, 27, 28] Contrary to O'NEAL's contentions, the fact that the services were ultimately provided and payment therefor made by FHP does not remove the claim from the HCFA review process. Rather, the question is whether the claims raised by O'NEAL are ***inextricably intertwined*** with the provision or denial of Medicare benefits. *Id,* at 101-102; See also, *Bodimetric Health Services v. Aetna Life & Cas., supra*, 903 F.2d at 487.

In this case, O'NEAL's claims are ***inextricably intertwined*** with her claim for benefits. O'NEAL's claims cannot succeed on any cause of action ***unless*** O'NEAL establishes that she was entitled to receive the rehabilitation treatment at issue. That determination is squarely within the purview of the HCFA, and *Heckler*, *Bodimetric* and *Redmond* teach that the review of the denial or delay in provision of that treatment ***must*** first be obtained through the HCFA review process.

Likewise, O'NEAL argues, as did Redmond, that her consequential damages cannot be remediated through the HCFA process. [Petition 21 - 23] In so doing, O'NEAL ignores the clear language of 42 U.S.C. § 1395 mm (I)(6) providing the Secretary of Health and Human Services with the express power "to impose civil money penalties, suspension of enrollment of individuals or suspension of payment to the organization" against any HMO that fails to provide medically necessary treatment. Likewise, O'NEAL ignores the *Redmond* Court's holding that the imposition of such penalties by the Secretary of Health and Human Services provides an ***adequate remedy*** for the patient. *Redmond v. Secure Horizons, supra,* 60 Cal.App.4th at 103 [Emphasis added].

Finally, O'NEAL's argument that the *Redmond* Court misquoted the applicable Federal Statutes through the use of ellipses is mistaken, at best. [See, Petition 20 - 21] Clearly, the *Redmond* Court mis-cited the applicable federal statutes when it referred to 42 U.S.C. § 1395ff(a) in its Opinion [See, *Redmond v. Secure Horizons*, *supra*, 60 Cal. App. 4th at 101]. Obviously, this mis-citation was a typographical error. The correct citation is 42 U.S.C. §1395mm(c)(5)(B), and is cited throughout the *Redmond* Opinion, including twice in the same paragraph where the mis-

citation referenced by O'NEAL appears. It is clear that while section 1395ff applies to the administrative review of non-HMO claims, section 1395mm controls administrative review of HMO claims. See, *Roen vs. Sullivan, supra*, 764 F. Supp. at 561. ***The two processes are identical***. They are merely set forth in different sections of the controlling statute. O'NEAL's reliance upon this obvious typographical error in the *Redmond* Opinion is appalling.

In sum, *Redmond* is squarely on point, both factually, procedurally, and legally, with the instant matter. The *Redmond* Court clearly and unequivocally held that actions for bad faith coverage determinations and breach of contract arising out of an HMO's failure to properly adjust a medical benefits claim, or any delay inherent therein, are preempted by the HCFA administrative review process. The *Redmond* decision is in accord with the controlling federal statutes [42 U.S.C. §1395mm(c)(5)(B); 42 U.S.C. § 405(b); 42 U.S.C. § 405(g)] and cases [*Heckler*, *Roen*, *Wilkins* and *Bodimetric*] in this area of the law. In light of this holding, it is clear that the Trial Court's Order sustaining Respondents' Demurrers *without leave to amend* was proper. There is no basis or reason for review by this Court.

III
THE FEDERAL CASES RELIED UPON BY O'NEAL ARE EITHER DISTINGUISHABLE OR INAPPLICABLE

A. *Ardary* Is Distinguishable

O'NEAL'S argument that her claims are exempt from the HCFA administrative review process is based primarily upon *Ardary v. Aetna Health Plans*, 98 F.3d 496 (9th Cir. 1996), *cert. denied*, 520 U.S. 1251, 117 S.Ct. 2408, 138 L.Ed.2d 174 (1997). [Petition 13 - 17] The *Ardary* decision and reasoning was expressly rejected by the California court in *Redmond* [*Redmond v. Secure Horizons, supra*, 60 Cal.App.4th at 103-104], and this rejection was based upon a sound analysis of the controlling federal cases and statutes. *Ardary* is similarly inapplicable to the instant appeal.

In *Ardary*, Cynthia Ardary suffered a heart attack. She was taken to Bear Valley Community Hospital, an approved facility under her Aetna Health Care plan, for emergency treatment. However, Bear Valley Hospital had neither intensive nor cardiac care facilities. Mrs. Ardary's Aetna plan physician recommended that she be transported by airlift transportation to Loma Linda University Medical Center, the nearest hospital having the necessary cardiac care facilities. However, Mrs. Ardary's HMO, Arrowest Physicians Association, refused to authorize the airlift. Mrs. Ardary died a few hours later at Bear Valley Hospital. *Ardary v. Aetna Health Plans, supra*, 98 F.3d at 497 - 498.

Mrs. Ardary's husband and children filed a state law wrongful death action against Aetna and Arrowest. The HMO Defendants removed the case to federal court, and then moved to dismiss on the ground that the Ardarys failed to participate in the HCFA administrative review process. The District Court granted the Motion to Dismiss, and the Ardarys appealed.

As the Ninth Circuit noted, the *Ardary* facts presented a *thorny jurisdictional question* – "Does the Medicare Act, which provides for exclusive administrative review of all claims 'arising under' that Act, apply to preclude the heirs of a deceased Medicare beneficiary from bringing state law claims for wrongful death against a private Medicare provider . . . ? " *Id,* at 499.

In holding that the Ardarys' claims were not within the purview of the HCFA administrative review process, the Ninth Circuit noted that "in certain special cases, deference to the Secretary's conclusion as to the utility of pursuing the claim through administrative channels is not always appropriate." *Id,* at 500 [citing *Heckler v. Ringer, supra*, 466 U.S. at 618]. Ultimately, the Ninth Circuit concluded that the Ardarys' claims were *not arising under* the Medicare Act because "[Mrs. Ardary's] death cannot be remedied by the retroactive authorization or payment of the airlift transfer." *Id.*, at 500. Therefore, the Ninth Circuit reversed the District Court's Order of Dismissal and remanded the case for further proceedings.

Ardary is a "special case." Unlike the instant matter, the *Ardary* claims were not brought by a Medicare beneficiary but,

rather, by the heirs of a person who died because she was ***totally denied*** the necessary emergency medical treatment. In fact, given the timing between the denial of the transfer and Mrs. Ardary's death, Mrs. Ardary and her family could not have participated in the HCFA administrative review process. By contrast, O'NEAL ***concedes*** that she was ***never*** denied the necessary treatment and merely asserts that Respondents delayed in the provision of some treatment. Moreover, O'NEAL's treatment lasted many months. Thus, O'NEAL had ample time and opportunity to participate in the HCFA administrative review process. Clearly, O'NEAL does ***not*** present a *special case* like was presented in *Ardary*.

Importantly, the *Ardary* analysis was *rejected* in *Redmond*.

> "We find *Ardary* distinguishable. In *Ardary*, the Ninth Circuit acknowledged that the United States Supreme Court had mandated in [*Heckler*] that the scope of the claims to which the administrative review process applied should be interpreted 'broadly' (*Ardary, supra*, at p. 500). However, the Ninth Circuit relied on a narrow exception carved out by the United States Supreme Court which permitted the exclusion of 'certain special cases' from the requirement that the claim be pursued 'through administrative channels' where these 'special' cases involved claims that could not be remediated through the administrative process. (*Ibid.*) Since the death of the health plan beneficiary in *Ardary* could not be remediated through pursuit of a posthumous coverage or benefits claim through the administrative process, the Ninth Circuit held that the administrative review process was inapplicable to the wrongful death cause of action. (*Ibid.*) Hence, the claim could be brought in state court. (*Id.* at pp. 500-501.)

> Whether or not we agree with the Ninth Circuit's resolution of the issue posed in *Ardary*, *Ardary*'s holding is not applicable here. This case, unlike *Ardary*, does not involve a claim which is so 'special' that it could not have been remediated by pursuit of a claim through the administrative review process. **Delays in the reimbursement of claims are commonplace, and the injuries allegedly suffered by [Redmond] are not so 'special' that she falls within the narrow exception to the otherwise universal requirement that the administrative review process must be pursued prior to any judicial review. Unlike the beneficiary in Ardary, [Redmond] had the distinct advantage of obtaining payment of her benefits claim without having had to avail herself of the lengthy administrative review process. The exceptional circumstances present in Ardary are not present here."**
>
> *Redmond v. Secure Horizons, supra*, 60 Cal.App.4th at 103-104 [Emphasis added].

The *Redmond* Court's reasoning in distinguishing *Ardary* is squarely applicable here. Like Redmond, O'NEAL received all of the treatment to which she was entitled and all of that treatment was paid for by Respondents. [Petition 10, 11, 12, 22, 23, 27, 28] Moreover, O'NEAL was not required to avail herself of the HCFA administrative review process to obtain the necessary treatment/payments; rather, FHP voluntarily provided all of the necessary treatment in response to verbal requests for reconsideration by O'NEAL's son. As the *Redmond* Court held, these facts do not present "the *exceptional circumstances* necessary to fit within the *narrow exception* for *special cases* carved out by the Supreme Court in *Heckler*." *Redmond v. Secure Horizons, supra*, 60 Cal.App.4th at 103-104. Therefore, *Ardary*

is factually and legally distinguishable, and is inapplicable to the instant matter. The Trial Court correctly dismissed O'NEAL's claims. No basis for review by this Court exists.

B. *Wartenberg* and *Plocica*, Like *Ardary*, Are Distinguishable

Two other federal cases relied upon by O'NEAL – *Wartenberg v. Aetna U.S. Health Care, Inc.*, 2 F.Supp.2d 273 (E.D.N.Y. 1998) and *Plocica v. Nylcare of Texas*, 43 F.Supp.2d 658 (N.D. Tex. 1999) – are factually and procedurally analogous to *Ardary* and, like *Ardary*, are distinguishable from this case.

In *Wartenberg*, Betty Lieberman was enrolled in a HMO plan administered by Aetna. On Thanksgiving in 1996, Lieberman was admitted to a hospital emergency room with a severe case of pneumonia. She remained in the hospital for six days. Before she recovered from her illnesses, and although she was in no condition to be discharged, Lieberman was discharged from the hospital to a nursing facility where she received skilled care. Three days after her admission to the skilled nursing facility, Lieberman was discharged from the facility on instructions from Aetna's plan physician. After being at home for less than one week, Lieberman was readmitted to the hospital in critical condition. Despite her grave condition, Lieberman was once again quickly discharged from the hospital and readmitted to a skilled nursing facility. Within 48 hours, she was returned to the hospital in acute respiratory distress, where she was attached to a respirator and placed in the Intensive Care Unit. Two weeks later, Lieberman died. *Wartenberg v. Aetna U.S. Health Care, Inc.*, *supra*, 2 F. Supp.2d at 273.

Following Lieberman's death, her nephew, Bernard Wartenberg, sued Aetna alleging that Aetna caused Lieberman's death by transferring her from hospital to hospital, from facility to facility, and by making imprudent medical decisions on her behalf. Claiming medical malpractice arising from his aunt's treatment, Wartenberg sought recovery of burial costs and punitive damages. *Id*, at 274.

Aetna moved to dismiss the case based upon Lieberman's failure to participate in the HCFA administrative review process. In ruling on this motion, the District Court framed the *decisive issue* as whether the wrongful death claims arose under and, therefore, were preempted by the Medicare Act.

Citing this Court's decision in *Heckler*, the District Court noted that if the claim was wholly collateral to a claim for benefits, and if the Plaintiff made a colorable showing that his injury could not be remedied by the retroactive provision of benefits, then participation in the administrative process would not be required. *Id.* at 275. To resolve this issue, the *Wartenberg* Court relied heavily upon the Ninth Circuit's reasoning in *Ardary*. After discussing the *Ardary* Court's reasoning, the *Wartenberg* Court concluded that because Wartenberg was only suing for damages stemming from his aunt's wrongful death, the claim was not *inextricably intertwined* with a claim for benefits, *Id.* at 277. Accordingly, Aetna's Motion to Dismiss was denied. No appeal was taken.

Plocica, like *Ardary* and *Wartenberg,* is also a wrongful death case. Joe Plocica suffered from severe and varying bouts of depression. He had attempted suicide on a number of occasions. Plocica was being treated for this condition by his personal physician, Dr. Eudaly, through his HMO, Nylcare of Texas. *Plocica v. Nylcare of Texas, supra*, 43 F.Supp.2d at 663.

On June 25, 1998, Plocica was admitted to the hospital following an overdose of prescription medication. The following day, Plocica was transferred to the psychiatric ward of another hospital, where he remained until he was discharged by order of his HMO on July 8, 1998. The discharge was made over the written objections of Plocica's physician, Dr. Eudaly.

The following day, Plocica ingested a half gallon of antifreeze in yet another suicide attempt. This time, Plocica was successful. He died eight days later. *Id,* at 663.

Plocica's heirs sued Nylcare and Dr. Eudaly for wrongful death, alleging that Plocica received an "inadequate quality of care and treatment" from his HMO and his treating physician. *Id,* at 664. Nylcare and Dr. Eudaly removed the case to the District

Court based upon the provisions of the Medicare Act. The Plocica heirs then moved to remand the case to the Texas state court, arguing that they were not required to participate in the Medicare review process, and that the case should proceed in the state court on their common law wrongful death claim.

After discussing and analyzing the *Ardary* and *Wartenberg* decisions, the *Plocica* Court granted the motion to remand. The Court held that the heirs' wrongful death claims were not subject to the Medicare review provisions, concluding:

> ". . . The Plocica's assert that '[p]ursuing the administrative Medicare appeal process, the remedy which defendants appear to be arguing for, would be a ***futile act*** since Joe Plocica is dead.'"

Id, at 663 - 664 [Emphasis added].

Wartenberg and *Plocica*, like *Ardary*, fall within the narrow, ***special case*** exception identified in *Heckler*. In *Ardary*, *Plocica* and *Wartenberg*, the plaintiffs' claims sounded in wrongful death. Likewise, in each of these cases the Plaintiffs' decedents died rapidly, precluding their participation in the HCFA administrative review process. Thus, to reject the *Ardary*, *Wartenberg* and *Plocica* claims based upon the administrative preemption doctrine would have deprived the Plaintiffs in those cases of any remedy whatsoever.

The instant matter is factually, procedurally, and legally distinguishable from *Ardary*, *Wartenberg* and *Plocica*. O'NEAL has successfully recovered and is still alive nearly four years after the onset of her stroke. Further, unlike the patients in *Ardary*, *Wartenberg* and *Plocica*, O'NEAL was ***never*** denied any medical treatment. In fact, she ***concedes*** that she received ***all*** of the treatment to which she was entitled ***and*** that FHP paid for ***all*** of that treatment. [Petition 10, 11, 12, 22, 23, 27, 28]. In a nutshell, O'NEAL's claims arise solely from the fact that she believes that

the determinations of whether the benefits at issue were covered under her FHP medical plan were unnecessarily delayed.

O'NEAL's claims are *inextricably intertwined* with her claim for benefits. If FHP was correct in assessing O'NEAL's benefit determinations, then her claim fails because she was not entitled to receive the services at issue. If the services at issue were covered by the Medicare guidelines, then O'NEAL's claim fails because of the administrative preemption doctrine. ***In either case, the threshold issue is whether the rehabilitative therapy in question was covered under the Medicare guidelines***. Pursuant to 42 U.S.C. § 1395, *et seq.*, that decision is exclusively confined to the HCFA administrative review process, and the final determination thereof must be made by the Secretary of Health and Human Services. Since O'NEAL failed to participate in that process, the California courts lacked the subject matter jurisdiction to entertain her claims. 42 U.S.C. § 405(g); *Redmond v. Secure Horizons, supra*, 60 Cal.App.4th at 104.

C. The Other Federal Cases Cited by O'NEAL Are Inapplicable

O'NEAL also relies upon four other federal cases – *Talbot v. Lucy Corr Nursing Home*, 118 F.2d 215 (4th Cir. 1997), *Berman v. Abington Radiology Associates*, 1997 WL 534804 (E.D. Pa. 1997), *Zamora-Quezada v. Health Texas*, 34 F.Supp.2d 433 (W.D. Tex. 1998), and *Winkler v. Interim Health Services, Inc.*, 36 F.Supp.2d 1026 (M.D. Tenn. 1999). As will be shown herein, each of these cases in inapplicable to the case at hand.

Talbot was an action under the residents' rights protections of 42 U.S.C. § 1983. Talbot alleged that she had been wrongfully evicted from the defendants' nursing care facility because of her complaints about her living conditions and the quality of her care. *Talbot v. Lucy Corr Nursing Home*, *supra*, 118 F.2d at 217. The defendants moved to dismiss, arguing that Talbot had failed to exhaust her ***state law*** administrative remedies. *Id*, at 218. The Medicare Act's administrative review process and the preemption created thereby were not even raised by the

defendants. In fact, the District Court ***expressly stated*** that the Medicare Act's administrative exhaustion requirement was inapplicable to the plaintiffs' claims arising from her eviction. *Id.* at 219, *fn.* 1. *Talbot* has no application to this case.

Berman is likewise inapplicable. Berman was a medical malpractice action in which Berman sued her physicians for misdiagnosing her breast cancer. The sole allegations of the Complaint were that Berman's physicians were professionally negligent in her care, and that their employer was negligent in their hiring practices and in the monitoring of their physicians' conduct. *Berman v. Abington Radiology Associates, supra*, 1997 WL 534804, 2. No claims were made that any benefits were denied or withheld, nor were any Medicare Act standards at issue. In the end, the District Court held that malpractice claims against a physician do not *arise under* the Medicare Act when the only question is whether the treatment at issue was properly rendered. *Id.* at 4. No such claims were alleged by O'NEAL herein. Thus, *Berman* provides no support for her position.

O'NEAL's reliance on *Zamora-Quezada* is likewise misplaced. *Zamora-Quezada* was an Americans with Disabilities Act [42 U.S.C. § 12182(a)] ("ADA") and Rehabilitation Act [29 U.S.C. § 794] claim alleging that patients were denied certain items of care based upon their levels of disability. The defendants moved to dismiss the claims based upon the patients' failure to participate in the Medicare administrative review process. After considering the parties' arguments, the District Court held that the Medicare administrative review process was inapplicable because the issue of the plaintiffs' entitlement of benefits under their Medicare coverage was not raised. *Zamora-Quezada v. Health Texas, supra*, 34 F.Supp.2d at 439 - 440. As the Court stated:

> "The amended complaint reveals plaintiffs are not seeking Medicare benefits. The standing and the substantive basis for their claims is not the Medicare Act. Instead, plaintiffs allege defendants engaged in a practice of discouraging the disabled from seeking treatment in violation of the ADA

> and Rehabilitation Act. These theories have their genesis in illegal discrimination and are not related to the furnishing of Medicare benefits while plaintiffs were enrolled with Humana."

Id. at 439 - 440.

Zamora-Quezada is to be contrasted with O'NEAL's claims. O'NEAL's claims are directly related to her entitlement to the benefits in question, and she seeks to recover damages for the alleged delay in providing those benefits. If O'NEAL was not entitled to the benefits, her claims fail on a substantive level. Thus, both the standing and the substantive basis for O'NEAL's claims is in the Medicare Act. Based upon this distinction, *Zamora-Quezada* in inapplicable to O'NEAL's claims

Finally, *Winkler* is not only inapplicable, it supports Respondents' position. The *Winkler* plaintiffs alleged that they were ***totally denied*** benefits based upon the level of their disabilities. Like the plaintiffs in *Zamora-Quezada*, the *Winkler* plaintiffs sought relief under the Rehabilitation Act and alleged ancillary state law damage claims. *Winkler v. Interim Health Services, Inc., supra*, 36 F.Supp.2d at 1027.

The defendants moved to dismiss the Winklers' claims, alleging a lack of subject matter jurisdiction because the plaintiffs had failed to proceed through the Medicare Act's administrative review process. After reviewing this Court's reasoning in *Heckler*, the District Court denied the motion, holding that where the services are ***totally denied***, the Medicare administrative review process is inapplicable. *Id.* at 1028.

Thus, the distinction between O'NEAL's claims and those of the plaintiffs in *Winkler* is that O'NEAL was never denied any services. Therefore, her claims are subject to the administrative review requirements of the Medicare Act. Because the *Winkler* plaintiffs were totally denied the benefits which they sought, and because their claims were alleged under the Rehabilitation Act [which contains no administrative review requirements], they

were not subject to the Medicare Act's subject matter jurisdiction/preemption requirements.

In sum, O'NEAL seeks to improperly expand *Ardary*, *Wartenberg*, *Plocica* and the other federal court decisions beyond their narrow parameters. O'NEAL fails to cite any case where a patient [or their heirs] has been allowed to pursue state law remedies against an HMO where [1] they did not die prior to having the opportunity to participate in the Medicare review process [*Ardary*, *Wartenberg* and *Plocica*], or [2] the claim was based upon a federal statute [e.g. ADA or Rehabilitation Act] which has no administrative review requirement [*Zamora-Quezada* and *Winkler*]. As such, the California courts properly dismissed O'NEAL's claim. There is no basis for review by this Court.

IV
PUBLIC POLICY SUPPORTS THE PREEMPTION OF O'NEAL'S CLAIMS

RECHE CANYON respectfully submits that, in addition to the statutory and case law authority compelling the rejection of O'NEAL's claims, public policy also mandates this result. O'NEAL, like tens of millions of other elderly Americans, receives her basic medical treatment through the federally funded and supervised Medicare program. The aim of this program is to provide efficient, medically necessary care to the elderly at a reasonable cost. In order to achieve this result, Congress and the Secretary of Health and Human Services have adopted guidelines for the cost of most medical procedures, and have determined that many procedures are not covered by the Medicare program. The task of applying the Medicare guidelines, in most cases, falls upon the HMOs and, more particularly, the individual HMO physicians. To ensure that the process is orderly and cost effective, Congress has adopted a streamlined administrative review process.

In this action, O'NEAL seeks to circumvent that administrative process. In essence, she contends that because the services she desired were not provided promptly enough, or as

frequently as she desired, she should be entitled to sue her caregivers for money damages for misapplying the Medicare statutes or applying them too slowly. O'NEAL raises these claims notwithstanding the fact that she actually received ***all*** of the medical treatment which she sought.

If claimants such as O'NEAL are allowed to proceed in the courts without first participating in the HCFA administrative review process, HMOs, medical professionals and insurance companies will be besieged with claims. Every time a patient believes they are entitled to a treatment, or they do not receive a requested treatment immediately, they will sue or threaten to sue. The interim result will be chaos; the end result will be that medical professionals and insurance companies will refuse to participate in the Medicare system. At bottom, America's elderly and infirm will be hard-pressed to find quality medical treatment on anything other than a *private pay* basis. This is not a desired result. As Chief Justice Rehnquist stated in *Heckler*:

> "In the best of all worlds, immediate judicial access for all of these parties might be desirable. But Congress, in Section 405(g) and Section 405(h), struck a different balance, refusing declaratory relief and requiring that administrative remedies be exhausted before judicial review of the Secretary's decisions takes place. **Congress must have felt that cases of individual hardship resulting from delays in the administrative process had to be balanced against the potential for overly casual or premature judicial intervention in an administration system that processes literally millions of claims every year. If the balance is to be struck anew, the decision must come from Congress and not from this court."**
>
> *Heckler v. Ringer, supra*, 466 U.S. at 627. [Emphasis added]

As *Heckler* teaches, Congress has recognized that the effect of government subsidized medicine is that individual patients will occasionally be required to forego some of their personal preferences in exchange for the common good, *to wit*: efficient and cost-effective medical treatment for the masses. Congress recognized this fact when it limited the Medicare beneficiaries' right to institute private actions against HMOs arising out of benefit determinations, and imposed the cost-effective HCFA administrative review process.

This process is beneficial to the Courts, as well. The HCFA administrative review process is designed to handle benefits determination reviews promptly, in most cases within a few weeks. The streamlined process is administrative in nature, does not require attorneys, and is supervised by a neutral, independent third party – the Secretary of Health and Human Services. By contrast, if claimants such as O'NEAL are permitted to pursue their claims in the Courts, the claims will take a year or more to resolve, will require attorney participation on all sides, and will be extremely expensive for all concerned. In addition to the congestion which this will add to the Courts, such litigation might financially collapse HMOs and/or health insurance carriers.

In sum, the relief sought by O'NEAL herein is detrimental to all concerned except O'NEAL. O'NEAL had the opportunity to seek redress of her claims through the HCFA administrative review process, and elected not to participate. Public policy dictates that she should not later be entitled to commence litigation after ignoring this statutorily prescribed remedial process.

CONCLUSION

Pursuant to the Medicare Act, O'NEAL's claims fall squarely within the purview of the HCFA administrative review process. Through that process, O'NEAL could have obtained a determination as to whether the rehabilitation treatment and therapy which she desired was a covered benefit for which FHP was required to pay, and also could have pursued civil, monetary

and administrative remedies against Respondents arising from the alleged delay in processing her claims. O'NEAL voluntarily elected not to participate in this administrative review process. Having done so, O'NEAL's attempt at judicial litigation is precluded both by the Medicare Act [42 U.S.C. 1395mm(c)(5)(A); 42 U.S.C. § 405(g) and (h)] and federal and California case law. Therefore, the Trial Court properly sustained Respondent's Demurrers to O'NEAL's First Amended Complaint *without leave to amend*, and that Judgment was correctly affirmed by the California Appellate Courts. There is no legal or public policy basis for this Court to review the California Courts' decisions.

WHEREFORE, Respondents RECHE CANYON REHABILITATION AND HEALTHCARE CENTER, INC. and CYNTHIA M. GLEASON respectfully request that the instant Petition for a Writ of Certiorari be ***DENIED***, and that Respondents be awarded their costs on appeal.

Respectfully submitted,

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